F. Subpart G -- Strategic Planning, Reporting, and Evaluation

1. Basis, scope, and applicability (§457.700)

As proposed, this subpart sets forth the State plan requirements for strategic planning, monitoring, reporting, and evaluation under title XXI. Specifically, this subpart implements sections 2107(a), (b), and (d) of the Act, which relate to strategic planning, reports, and program budgets; and section 2108 of the Act, which sets forth provisions regarding annual reports and evaluations.

In the preamble to the proposed rule, we noted the importance of reporting and evaluating SCHIP data. We stated that these activities will provide the critical information necessary for meeting Federal reporting requirements, documenting program achievements, improving program function, and assessing program effectiveness in achieving policy goals. We also described that our information dissemination policy will include making State annual reports, State evaluations and a summary of State expenditures and statistical reports regularly available on the Internet.

Comment: Several commenters strongly supported the statement in the preamble to proposed §457.700 indicating that we plan to make annual reports, State evaluations, and summaries of State reports regularly available for public access on the Internet. One commenter recommended that an annual, separate,

consumer-friendly SCHIP State-by-State status report be available in written and electronic form to the public.

Response: We plan to continue the information dissemination policy that includes making annual reports, State evaluations, and a summary of State expenditures and statistical reports regularly available on the Internet, to the maximum extent possible. We have already produced two State-by-State reports on SCHIP enrollment and released a summary of the States' March 31, 2000 evaluations. We plan to produce and make available future informational reports based on State evaluations, enrollment data, and other sources. We encourage the public not only to access our web site to read the State annual reports and other State-specific information but also to access individual State web sites. In addition, we note that several national organizations, such as the National Governors' Association (NGA), the National Academy for State Health Policy (NASHP), the Children's Defense Fund, the National Conference of State Legislators (NCSL), the American Public Human Services Association (APHSA), the American Academy of Pediatrics (AAP), and other organizations representing State and local governmental entities periodically produce State-by-State SCHIP status or informational reports that are available to the public. We encourage the public to utilize these resources.

Comment: Several commenters stated that we should require

States to collect information in a manner that does not discourage individuals from applying for SCHIP. Techniques suggested for achieving this goal include: explaining to participants the purpose of the information collected, assuring confidentiality of information collected, and disclosing that the failure to provide the requested information will not be used to deny eligibility.

Response: We agree with commenters on the importance of gathering evaluative information without creating barriers to participation in SCHIP; and we know this is a concern for States and other stakeholders who have worked to simplify and streamline the application process. We also recognize the flexibility given to States in creating and evaluating their uniquely designed SCHIP programs. We encourage States to be mindful of potential barriers created by collecting information and to create systems that do not prevent potential enrollees from applying for health insurance coverage under SCHIP.

In addition, as noted later in the responses to comments on §§457.740 and 457.750, in conjunction with the requirement that States collect and report information about the gender, race, ethnicity and primary language of SCHIP enrollees; we emphasize the importance of States ensuring through the application process that failure to provide information on one of these areas will not affect a child’s eligibility for the program. In addition,

States must request this information in a manner that is linguistically and culturally appropriate so as not to discourage enrollment in the program.

2. State plan requirements: Strategic objectives and performance goals (§457.710)

In accordance with section 2107(a) of the Act and the Government Performance and Results Act of 1993 (GPRA), proposed §457.710 encouraged program evaluation and accountability by requiring the States to include in their State plan descriptions of the strategic objectives, performance goals, and performance measures the State has established for providing child health assistance to targeted low-income children under the plan and for otherwise maximizing health benefits coverage for other low-income children and children generally in the State.

In accordance with section 2107(a)(2) of the Act, we proposed at §457.710(b) that the State plan must identify specific strategic objectives related to increasing the extent of health coverage among targeted low-income children and other low-income children. We encouraged States to view the development of strategic objectives as a process that involves translating the basic overall aims of the State plan into a commitment to achieving specific performance goals or targets, recognizing that there will be variation among States in specific evaluation approaches and terminology. One of the strategic objectives

established in the Act is the reduction in the number of low-income, uninsured children.

Under section 2107(a)(3) of the Act, States must identify one or more performance goals for each strategic objective. We proposed to implement this statutory provision at §457.710(c). We noted in the preamble that detailed performance goals should facilitate the State's ability to assess the extent to which its strategic objectives are being achieved. In addition, we provided guidance on factors States should consider in drafting strategic objectives and performance goals, noting that they should consider not only the general population targeted for SCHIP enrollment, but special population subgroups of particular interest as well.

In accordance with section 2107(a)(4) of the Act, proposed §457.710(d) provides that the State plan must describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals. We set forth specific examples of acceptable performance measures in the preamble to the proposed rule.

Comment: We received several comments suggesting that we require States to report on a common core of widely-used, objective, standardized, and child-related performance measures and strategic objectives designated by the Secretary. Furthermore, commenters recommended that we require the results

of these standard performance measures to be included in the States' annual reports. Some commenters feared that, absent a requirement to report a common set of measures, the information collected might be meaningless and could not be used to evaluate or compare the effectiveness of State plans.

Commenters recommended strategic objectives including: the need to reduce and/or eliminate racial and ethnic disparities in children's health insurance coverage; the need to reduce and/or eliminate barriers to health coverage for children with disabilities; the need to reduce stigma and barriers to access in Medicaid; the need to ensure that the goal of increasing coverage for uninsured children does not supplant or overshadow the importance of ensuring that the receipt of health benefits coverage results in the provision of quality health care and improves health outcomes. Commenters believed that HCFA should consult with the States in creating these national standards, and in doing so, build upon the efforts of other Federal agencies, such as the performance measures developed for State Maternal and Child Health Services Block Grants by the Health Resources and Services Administration.

Response: We agree there should be a common core of evidence-based, standardized, child-related performance measures and performance goals. These measures and goals can be used to evaluate the overall effect of the program in access, service

delivery, processes of care and health outcomes with the intent of improving the quality of care, particularly in the areas of well-baby care, well-child care, well-adolescent care, and childhood and adolescent immunizations. Section 2701(b)(1) of the Act and proposed §457.20 directs that State plans must include assurances that the State will collect data, maintain records, and provide reports to the Secretary at the times and in the format the Secretary may require. The development of common quality and performance measures and goals is essential to assessing the national impact of the SCHIP program and we have modified the regulation text at §457.710(d)(3) to provide that the Secretary may prescribe a common core of national measures.

However, we also acknowledge the difficulties in achieving national consensus on specified measures. Therefore, HCFA will convene a workgroup to develop a set of core performance measures and performance goals incorporating appropriate quality assurance indicators, and the methodology for implementing common measures and goals for SCHIP in an appropriate and timely manner. As we undertake this effort, we will be guided by the objectives, goals and measurement methods States have developed, as described in their annual reports and evaluations.

The development of national performance indicators and goals does not diminish the importance of having States identify their own specific strategic objectives, and accompanying performance

goals and measurements. While States may be required to adopt national performance measures and goals once they have been developed, we expect States to implement their own performance measures, performance goals and strategic objectives specific to the unique design and priorities of their own program. States, in accordance with section 2107(a)(4) of the Act, will continue to be required under §457.710 to establish State-specific performance measures and to describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals.

Comment: One commenter suggested that HCFA recommend to States the following outcome measures: out-of-home placements, the Children and Adolescent Functional Assessment Scale (CAFAS), days-in-school, school performance, and reduced involvement in the legal system.

Response: We agree with the commenter that measures from a variety of sources can be useful in evaluating the impact of SCHIP on the health and the behavior of participants and we would encourage States to take them into consideration as they develop their State-specific performance measures. Additionally, as we convene a workgroup to discuss the development of national core performance and quality assessment measures, we will consider the measures the commenter has suggested. We are mindful, however, that SCHIP's first goal is to expand coverage to uninsured

children and that, while it is generally believed that coverage and better access to health care can lead to improvements in school attendance and school achievement, it is difficult to isolate the cause and effect of changes in social behavior that are influenced by a wide range of factors and circumstances.

Comment: We received one comment expressing concern that the willingness and ability of managed care entities (MCEs) to participate in SCHIP depended on whether the revenues adequately covered the MCEs' costs. The commenter noted that costs associated with collecting and validating data may be substantial, and thus may prevent MCEs' from participation in the program. The commenter expressed concern that the MCE might not have a large enough population of SCHIP participants to generate statistically valid data. Additionally, the commenter asserted that HCFA has failed to establish realistic goals for Quality Improvement System for Managed Care (QISMC)-related health plan activities and performance that take into consideration available resources and responsibilities for the delivery of quality care for beneficiaries.

Response: We recognize the concerns expressed by the commenter. However, we disagree that the requirements in the proposed regulation may impose an undue financial hardship upon MCEs. This regulation provides States with significant flexibility regarding the performance measurements they will use

and the preamble to the proposed rule encouraged States to review measures, including those widely used by private-sector purchasers of MCE services. We suggested in the preamble of the NPRM that States may wish to consider adopting standardized methods and tools in quality assurance and improvement, such as those of the QISMC initiative, but we did not propose and are not requiring the use of QISMC-related measures. However, the burden on MCEs would be minimized to the extent a State chooses measures that the MCEs are already using in connection with other programs.

In any event, the regulation imposes obligations on States and does not directly govern actions of MCEs. While we require States to report data relating to their strategic objectives and specific performance goals, we are aware of the difficulty in compiling statistically valid data in small sample sizes and are mindful of States' interest in reducing burden for their MCEs. The regulation does not require that States collect encounter data. States have the option of choosing other methods of collecting data related to their strategic objectives, including, but not limited to, surveys of SCHIP participants and/or SCHIP health care providers and looking at encounter data, to the extent it is available.

Comment: One commenter urged HCFA to include the American College of Obstetricians and Gynecologists educational bulletin

entitled "*Primary and Preventive Health Care for Female Adolescents*" in the list set forth in the preamble of examples of widely recognized measures and guidelines states should review in developing performance measures for SCHIP programs.

Response: We agree with the commenter that there may be several measures beyond those we specifically mentioned in the preamble to the proposed rule that States might find helpful in translating their strategic objectives into performance measures and goals. We encourage States to consider this bulletin as well as others that provide widely-used performance measures for children's and adolescent's health and health care.

Comment: A couple of commenters indicated that while the Health Employer Data and Information Set(HEDIS) was designed to be reported at the health plan level, plan-reported numerators and denominators can be added together to yield aggregate State-level reports that could help measure performance in reaching State enrollment targets and in delivering high quality health care. The commenters indicated that HEDIS measures are objective, validated measures of health plan performance (on quality, access and availability, and the use of services) and, when audited using the HEDIS Compliance Audit, performance measures are independently verified. In addition, the commenters stated that national benchmarks exist for both the commercial and Medicaid populations which can be used to establish performance

goals and to evaluate performance of a specific health plan or State SCHIP program. One commenter noted that the National Committee on Quality Assurance (NCQA) offered to work with HCFA and States on implementation strategies, including making HEDIS specifications broadly available.

Response: We agree that HEDIS may be a useful tool for States in measuring their performance and establishing goals. We appreciate NCQA's willingness to assist with SCHIP implementation and are working with them to develop HEDIS specifications for SCHIP. In States that are considering using HEDIS measures, we have recommended the following approach to reporting data and information on SCHIP programs: Where a State contracts with managed care entities (MCEs) for health benefits coverage for SCHIP enrollees, States should, where possible, identify individual SCHIP enrollees for its contracting MCEs as detailed below.

If the State has identified SCHIP enrollees to a contracting MCE, and the contracting MCE also contracts with the State Medicaid program, then the MCEs should, as directed by the State either: 1) report the required HEDIS measures separately for SCHIP enrollees; or 2) include SCHIP enrollees in their Medicaid product line reports.

If the State has identified SCHIP enrollees to a contracting MCO and the contracting MCE is a commercial MCE without a

Medicaid product line, the MCE should exclude SCHIP enrollees from its commercial product line reports, because including SCHIP enrollees in HEDIS reports for commercially enrolled populations may affect commercial MCE-to-MCE comparisons. Under these circumstances, HEDIS performance measures for SCHIP enrollees will need to be reported separately. In addition, MCEs with small numbers of eligible SCHIP enrollees should follow the small numbers general guideline. These specifications will be included in the HEDIS guidelines for 2001.

Comment: In response to HCFA's solicitation for comments on additional measures that will assist in articulating the success of programs implemented under title XXI, several commenters recommended the following performance measures:

Access

-- Percentage of Medicaid eligible enrolled in Medicaid;

-- Percentage of SCHIP eligible enrolled in SCHIP;

-- Percentage of children with a usual source of health care;

-- Percentage of children with an unmet need for physician services and/or delayed care;

-- Reduction of hospitalization for ambulatory sensitive conditions;

-- Percentage of enrollees who are enrolled for a year or more;

-- Percentage of children who are identified as having special health care needs;

-- Percentage of employers offering health insurance coverage to employees and dependent children;

-- Percentage of enrollees whose parents decline employer-sponsored dependent health insurance coverage;

-- Percent of children whose eligibility switches between title XIX and title XXI who enroll in the appropriate program (or who maintain health insurance coverage);

-- Percentage of pediatricians, family physicians, and dentists who participate in Medicaid and SCHIP;

Process

-- Percentage of children and adolescents who have received immunizations according to the ACIP/American Academy of Pediatrics recommended immunization schedule;

-- Percentage of children and adolescents who have received all of the well-child visits appropriate for their ages, based on the American Academy of Pediatrics Recommendations for Pediatric Health Care;

-- Percentage of adolescents ages 12 though 18 who were counseled for symptoms or risk factors for STDs;

-- Percentage of children ages four through 18 during the reporting year who received a dental examination during that year;

-- Percentage of children ages three through six who received a vision screening examination during the reporting year;

-- Percentage of children and adolescents with all of the well-child visits provided at one health care site during the reporting year;

-- Percentage of children and adolescents, parents or caretakers with difficulty communicating with health care professionals because of a language problem or difficulty understanding health care professionals;

-- Percentage of children and adolescents with asthma who regularly use a peak flow meter during the reporting year, regularly use a spacer with a metered dose inhaler, and/or who received influenza vaccine during the reporting year;

-- Percentage of children with special health needs who received care during the reporting year;

Outcomes

-- Rate of hospitalization for ambulatory sensitive conditions such as asthma, diabetes, epilepsy, dehydration, gastroenteritis, pneumonia; or urinary tract infection (UTI);

-- Rate of hospitalization for injuries;

-- Percentage of children and adolescents reporting days lost from school due to health problems;

-- Percentage of children reporting risky health behaviors including injuries, tobacco use, alcohol/drug use, sexual behavior, poor dietary behavior, lack of physical activity;

-- Percentage of adolescents reporting attempted suicides;

-- Percentage of children reporting unmet medical needs;

-- Percentage of children reporting unmet vision needs;

-- Percentage of children reporting unmet dental needs; and

-- Percentage of family income used for medical and dental care.

Response: Assessments of the impact of the title XXI program on children's health insurance coverage, access to care and use of health care services will occur on both the State level and national levels. On the State level, we would encourage States to consider the commenters' suggested performance measures as they identify those measures which are appropriate for each of their strategic objectives as required under section 2107(a)(3) of the Act and §457.410(b).

Nationally, as HCFA works to develop a common core of standardized child-related performance measures, performance levels and quality measures that can be used to evaluate access, service delivery, processes of care, health outcomes and quality in the overall SCHIP program, we will consider the performance measures recommended by the commenters.

3. State plan requirement: State assurance regarding data collection, records, and reports. (§457.720)

Section 2107(b)(1) of the Act requires the State plan to provide an assurance that the State will collect the data, maintain the records, and furnish the reports to the Secretary, at the times and in the standardized format that the Secretary

may require to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans under title XXI. We proposed to implement this statutory provision at §457.720.

We did not receive any comments on this section and are therefore implementing the provision as proposed.

4. State plan requirement: State annual reports. (§457.730)

Section 2107(b)(2) of the Act discusses the requirement that the State plan include a description of the State's strategy for the submission of annual reports and the State evaluation.

Accordingly, we proposed to implement this provision at §457.730. We noted that, in order to facilitate report submission, a group of States worked with staff from the National Academy of State Health Policy (NASHP), with HCFA representation, to develop an optional model framework for the State evaluation due March 31, 2000 and for subsequent annual reports. We also noted that we would permit States to submit their FY 1999 annual report and their State evaluation on March 31, 2000, together as one comprehensive document. However, since the States evaluations/annual reports have all been submitted, this provision is unnecessary and has been deleted from the final rule. In addition, we have moved the discussion of the annual report requirements to comments and responses on §457.750.

Comment: One commenter recommended that we require States

to use a designated framework for submitting annual reports and evaluations. This commenter suggested that we include clinicians, child advocates and research groups to participate in the development of frameworks for future reports.

Response: While we do not believe it is necessary to require a designated framework for annual reports and evaluations, in order to facilitate report submission, a group of States worked with staff from NASHP and with representatives from HCFA to develop an optional model framework for the State evaluation due March 31, 2000. This framework was finalized and sent to every State and territory with an approved State plan. All States that have submitted their State evaluations have voluntarily used this framework as the basis for their evaluation, although several States supplemented their evaluations with additional data. We currently are in the process of analyzing and synthesizing the data submitted in these evaluations. We will continue to work with States and other interested parties to support these efforts to promote ease of reporting and to facilitate analysis and comparison of important data reported by States on their programs.

NASHP has subsequently developed a similar framework for the annual reports that States will be submitting in January 2001. As SCHIP development continues, we encourage continued participation in the evaluation process by interested

researchers, health care providers and provider groups, advocates and advocacy groups, insurance providers, State and local government officials, and other interested parties and intend to keep the process as open and collaborative as possible.

5. State expenditures and statistical reports (§457.740)

We proposed to require that the States collect required data beginning on the date of implementation of the approved State plan. We proposed that States must submit quarterly reports on the number of children under 19 years of age who are enrolled in separate child health programs, Medicaid expansion programs, and regular Medicaid programs (at regular FMAP) by age, income and service delivery categories. In the preamble, we noted that the Territories are excepted from the definition of “State” for the purposes of quarterly statistical reporting. We also proposed to require that thirty days after the end of the Federal fiscal year, the State must submit an unduplicated count for that Federal fiscal year of children who were ever enrolled in the separate child health program, the Medicaid expansion program and the Medicaid program as appropriate by age, service delivery, and income categories.

We proposed that the age categories that must be used to report the data are: under 1 year of age, 1 through 5 years of age, 6 through 12 years of age, and 13 through 18 years of age. We further proposed to require States to report enrollment by the

service delivery categories of managed care, fee-for-service, and primary care case management.

We noted in the proposed regulation and explained in the preamble that States must report income by using State-defined countable income and State-defined family size to determine Federal poverty level (FPL) categories. We proposed that States that do not impose cost sharing and States that only impose cost sharing based on a fixed percentage of income (such as 2 percent) in their Medicaid expansion program or their separate child health program must report their SCHIP and Medicaid enrollment by using two categories: at or below 150 percent of the FPL and over 150 percent of FPL. States that impose cost sharing at defined income levels (for example, at 185 percent and over of FPL) in their Medicaid expansion programs and/or separate child health programs would be required to report their Medicaid and SCHIP enrollment by poverty level (that is, countable income and household size) categories that match their Medicaid expansion program and separate child health program cost-sharing categories. We proposed to require enrollment reporting by income for Medicaid as well as for SCHIP.

We proposed that required standardized reporting be limited to expenditure data and enrollment data as reported by age, poverty level, and service delivery category. We noted in the preamble to the NPRM that States should collect other relevant

demographic data on enrollees such as gender, race, national origin, and primary language and that collecting such data will encourage the design of outreach and health care delivery initiatives that address disparities based on race and national origin.

We stated that we were working to develop an option for States to provide the needed SCHIP data through existing statistical reporting systems in the future.

Comment: One commenter suggested that we revise the regulations to specify that a State's failure to submit the statistical reporting forms would ordinarily be considered substantial non-compliance.

Response: Section 457.720 requires States to comply with data reporting requirements. Section 2106(d)(2) of the statute and §457.204(c) provide the Secretary with authority to enforce these and other requirements. We do not believe that it is necessary to specify more specific sanctions for non-reporting or delayed reporting within the rule.

We are working closely with States to develop and implement data tracking and reporting systems. SCHIP reporting may involve creating new systems or adjusting existing systems to collect data which can then be reported to DHHS and we recognize that the reporting changes required in this final rule may require further changes to these systems. We will work with the States to

accommodate individual needs for technical assistance during the transition.

In the past, some States have had difficulty reporting data to us in a timely matter due to systems constraints. However, we anticipate that many of these difficulties will be resolved in the near future. We recently implemented a new, more easily accessible web-based data reporting system (the Statistical Enrollment Data System (SEDS)) that all States can access through the Internet, rather than through the main frame system. We have also revised the reporting instructions to clarify definitions in a way that will be more clear for States and provide for more standardized reporting among the States. We released these new instructions with a letter to State Health Officials on September 13, 2000. In addition, we are continuing a comprehensive evaluation of possible modifications to the Medicaid Statistical Information System (MSIS), which captures State eligibility and claims records on a person-level basis. The modifications will give States the option of using MSIS to supply the data elements that will meet the title XXI quarterly statistical reporting requirements. We look forward to working with States to further improve the time lines and quality of required SCHIP data. In addition, we have added a new reporting line to the quarterly reports where States indicate a “point in time” enrollment count that indicates enrollment as of the last day of the quarter for

their SCHIP and title XIX Medicaid programs. This count is something the States already have available for their own purposes and helps provide a more complete picture of States' programs on an ongoing basis.

Comment: We received several comments requesting that HCFA require States to collect data pertaining to one or more of the following categories of information about enrollees and their SCHIP coverage: gender, ethnicity, race, primary language, English proficiency, age, service delivery system, family income, and geographic location. Certain commenters suggested that this data be collected and reported to HCFA in the State evaluations, annual reports, and/or quarterly statistical reports. These commenters felt this information would help target outreach, retention, enrollment, and service efforts to under-represented groups. These commenters also indicated that such reporting requirements are consistent with the goals of *Healthy People 2010* and recently enacted legislation directing the Secretary of Commerce to produce statistically reliable annual State data on the number of uninsured, low-income children categorized by race, ethnicity, age, and income. One commenter indicated that HCFA should require States to document the appropriate range of services and networks of providers available, given the various language groups represented by enrollees. Additionally, some commenters noted that HCFA should require States to provide an

assessment of their compliance with civil rights requirements.

Response: We agree with several of the comments summarized above. Section 2107(b)(1) of the Act requires that "a State child health plan shall include an assurance that the State will collect the data, maintain the records and furnish the reports to the Secretary, at the times and in the standardized format the Secretary may require in order to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans." The proposed rule at §457.740(a) had included requirements on States to collect and submit data by age categories, service delivery categories and by countable income. In an effort to streamline data reporting requirements, we had only encouraged States to collect data with respect to gender, race and ethnicity, and did not propose to require the collection or the reporting to HCFA of such data. We received many comments expressing concern about this policy and urging us to require States to report data on gender, race, ethnicity and primary language of SCHIP enrollees to HCFA.

We have reviewed our proposed policy and have decided that it is consistent with overall program goals, as well as the civil rights requirements, to require States to report data, on a quarterly basis, on the race, ethnicity, and gender of SCHIP enrollees using the format prescribed by the *OMB Statistical Directive 15 -- Standards for the Maintaining, Collecting and*

Presenting Data on Race and Ethnicity. We have therefore amended §457.740(a)(2) to reflect this requirement. Because primary language of SCHIP enrollees is not one of the data elements on standardized reporting formats, we will require States to report on this information as part of the Annual Report, and have amended §457.750(b)(8) to reflect this change. We understand that nearly all States have already been collecting this information through the application process. Although States may request information on gender, race, ethnicity and primary language at the time of application, States may not require families to report this data as a condition of application to, or enrollment in the SCHIP program. The information must be collected from SCHIP applicants and enrollees on a voluntary basis. Having this data will enable States and the Department to see how and if minority children and other categories of children are being covered by the SCHIP program and to identify opportunities for more effective outreach and retention strategies.

Furthermore, required reporting of this data is consistent with Departmental priorities to more effectively identify racial disparities in the provision of health care and to assure that language barriers do not interfere with children’s ability to secure health care. HCFA will modify its data base to permit States to report these data on the same system as they report

enrollment data. We understand States may incur additional administrative costs to comply with this requirement. However, the potential benefits for the States and for the Department are significant.

Comment: Commenters asserted that neither the State nor the health insurance purchasing cooperative has the legal authority to require employer-sponsored insurance carriers to report claims data. Therefore, commenters noted, States with premium assistance programs would have difficulty reporting program expenditures and participants by age, income, delivery system, and program type as required by HCFA.

Response: Since States or their contractors would be completing the eligibility process for children enrolling through premium assistance programs, States would have data available on the child's age, family income, the type of child health insurance program offered by the State, and the expenditures being made on behalf of the child. We are not requesting individual claims data used by group health plans providing SCHIP coverage. Service delivery systems could be ascertained by the State by reviewing the benefit package available through each employer. This might present difficulties if an employer had several options with varying delivery systems available at the same cost to the State. Should this be the case, we would work with States on a case-by-case basis to consider other options for

collecting this data.

Comment: One commenter noted that the collection report Form HCFA-64, revised in December 1998, requires additional information that is not reflected in §457.740, including number of months enrolled, and the number disenrolled per quarter. Several commenters suggested that HCFA require States to report this data to HCFA on a quarterly basis.

Response: In §457.740, we did not intend to specify each data element that we will be requiring, because we wanted to be able to review and modify specific elements as the program evolves. We have authority under section 2107(b)(1) to specify at §457.720, that States must provide data "at the times and in the standardized format..." to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans under title XXI. This includes the number of months enrolled and number disenrolled per quarter.

The forms referenced by the commenter are quarterly reports used by State Medicaid agencies to report to HCFA their actual Medicaid expenditures and the numbers of SCHIP children and other children being served in the Medicaid program. HCFA uses these forms to ensure that the appropriate level of Federal payments for the State's Medicaid expansion program expenditures, and to track, monitor and evaluate the numbers of SCHIP children being

served by the Medicaid expansion program. HCFA uses a similar quarterly reporting form, the HCFA-21, to collect comparable information on separate child health programs.

Comment: One commenter noted that the collection of data to measure the effectiveness of SCHIP should include the number and types of services actually delivered in addition to the number of children enrolled. This commenter suggested that we revise the regulations to specify that data can be collected and reported by the State using American Dental Association procedure codes to reflect total number of actual services rendered to eligible individuals.

Response: We agree States should consider utilization measures in developing Statewide performance measures of progress toward meeting State performance goals and strategic objectives. We also envision that States may want to measure care and service delivery so that they may determine numbers of participating providers and health networks needed for the program. The regulation provides States with flexibility in developing these measures and appropriate data collection methodologies.

As the Department works on developing and implementing a common core of standardized performance measures and performance goals, we will consider the outcome measures suggested by the commenter.

Comment: One commenter generally supported the quarterly

reporting requirements but requested one additional required report measure. Specifically, the commenter urged HCFA to require reporting (either annually or quarterly) on the number of newborns who are enrolled at birth and the number of infants who are enrolled within the first three months of life. The commenter believed this information could be used by States to assess whether income-eligible newborns are experiencing gaps in coverage between the time of birth and SCHIP enrollment.

Response: We strongly encourage the States to collect the required information on age of participants in such a way that they may analyze the health coverage patterns of newborns and infants. We have not required States to report this information to HCFA. However, we will consider the commenter's suggestion as we develop the national core set of performance measures and goals.

Comment: One commenter urged HCFA to require States to describe their income calculation methodologies and changes in those methodologies and to make that information available to the public.

Response: We agree with the commenter's suggestion and note that income calculation methodologies and changes to these methodologies were requested to be provided by States as part of their State evaluations (due to HCFA on March 31, 2000). Because of the importance of having this information in a standardized

manner, as well as keeping the information current, we have included this as an element of subsequent State annual reports. We have compiled and reviewed the submissions from the States thus far, and the information is available to the public along with the rest of the States' evaluations on the HCFA web site.

In addition, we discussed in our July 31, 2000 guidance on SCHIP section 1115 demonstrations that in order to receive approval for a demonstration proposal, States must have submitted all of their required statistical reports and evaluations to HCFA, dating back to the implementation of their program.

Comment: One commenter found the detailed reporting requirements problematic, cumbersome, and difficult to comply with under current automated systems.

Response: We recognize the commenter's concerns. However, we will continue to require the collection and quarterly reporting to HCFA of the data required in this section. We will continue to offer technical assistance to States having difficulty reporting the required data due to automated system difficulties. As noted previously, States are able to report data to HCFA through a web-based reporting system on the Internet, to provide States with easier access to the reporting system. In addition, we have developed a set of revised reporting instructions to facilitate reporting by States in a standardized format. We believe these modifications will result

in a reporting system with which States can comply with minimal difficulties.

In addition, we are continuing a comprehensive evaluation of possible modifications to the Medicaid Statistical Information System (MSIS), which captures State eligibility and claims records on a quarterly basis. The modifications will give States the option of using MSIS to supply data related to separate child health programs as well as Medicaid expansion programs and will promote overall consistency among SCHIP and Medicaid data in the long term.

Comment: We received several comments applauding our recognition of the interrelationship of Medicaid and SCHIP and the requirement of similar reporting for regular Medicaid, Medicaid expansion, and separate child health programs. However, one commenter opposed the requirement that all States, including those operating separate child health insurance programs, report changes in enrollment in both the SCHIP program and the Medicaid program. The commenter noted that some States operate separate child health programs that are administered by different staff, governing boards, budgets, etc. than the State Medicaid program. The commenter opposed a requirement that a separately administered SCHIP program have a contractual requirement to obtain data from a Medicaid agency. The commenter stated that if HCFA wished to review Medicaid data, it should develop new

Medicaid regulations to require such data and to provide reimbursement to the Medicaid agency as the SCHIP program has no budget or legal authority to collect Medicaid data. The commenter added that additional administrative requirements from HCFA should be accompanied by additional administrative dollars, or they represent unfunded mandates that exacerbate the 10 percent administrative-cost limit problem.

Response: The statute anticipates that State agencies implementing SCHIP and Medicaid will coordinate activities and share information. Section 2108(b)(1)(C) of the Act requires States to report on or before March 31, 2000 "an assessment of the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children." In addition, section 2108(b)(1)(D) specifically requires States to report on coordination with other public and private programs providing health care and health financing, including Medicaid programs. Furthermore, these requirements are not specific to the State agency administering SCHIP or Medicaid, but rather apply to the State as a condition of receiving grant funding under these programs, regardless of how the State internally delegates responsibilities under these programs.

In addition, section 2107(b)(1) of the Act requires that the State plan contain certain assurances regarding the collection of

data and submission of reports to the Secretary. In addition, §431.16 of the Medicaid regulations specifies that a State plan must provide that the Medicaid agency will submit all reports required by the Secretary, follow the Secretary's instructions with regard to the format and content of those reports, and comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. These statutory and regulatory provisions serve as our authority for requiring Medicaid State expenditure and statistical reporting at §457.740. State agencies can reasonably be expected, as directed in the statute, to coordinate among programs, including by sharing and reporting information.

Since Medicaid agencies receive Federal financial participation under title XIX for administrative costs, such as those associated with data collection, sharing this information with the States' title XXI programs should not exacerbate any difficulty States may have in staying within the 10 percent administrative cost limit in SCHIP.

6. Annual report (§457.750)

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must

assess the progress made in reducing the number of uncovered, low-income children. We proposed to implement the statutory provision requiring assessment of the program and submission of an annual report at §457.750(a).

At proposed §457.750(b), we set forth the required contents of the annual report. Specifically, in accordance with the statute, the annual report must provide an assessment of the operation of the State plan in the preceding Federal fiscal year including the progress made in reducing the number of uncovered, low-income children. In addition, we proposed to require that the State report on: 1) progress made in meeting other strategic objectives and performance goals identified by the State; 2) successes in program design and implementation of the State plan; and 3) barriers in program design and implementation and the approaches under consideration to overcome these barriers. We also proposed to require that the State report on the effectiveness of its policies for discouraging the substitution of public coverage for private coverage. Further, we proposed to require that the annual report discuss the State's progress in addressing any specific issues, such as outreach, that it agreed to monitor and assess in its State plan.

In accordance with section 2107(d) of the Act, we also proposed that a State must provide the current fiscal year budget update, including details on the planned use of funds for a

three-year period and any changes in the sources of the non-Federal share of plan expenditures. We also proposed that the State must identify the total State expenditures for family coverage and total number of children and adults covered by family coverage during the preceding Federal fiscal year.

We proposed that, in order to report on the progress made in reducing the number of uncovered, low-income children in the annual report, a State must choose a methodology to establish an initial baseline estimate of the number of low-income children who are uninsured in the State and provide annual estimates, using the chosen methodology, of the change in this number of low-income uninsured children at two poverty levels: 200 percent FPL and at the current upper eligibility level of the State's SCHIP program. We noted in the preamble to the proposed rule that, in making these estimates, a State would not be required to use the same methodology that it used in identifying the estimated number of SCHIP eligibles in the State plan.

We proposed to require that a State base the annual baseline estimates on data from either : (1) the March supplement to the Current Population Survey (CPS); (2) a State-specific survey; (3) other statistically adjusted CPS data; or (4) other appropriate data. We also proposed that a State must submit a description of the methodology used to develop these estimates and the rationale for its use, including the specific strengths

and weaknesses of the methodology, unless the State bases the estimate on the March supplement to the CPS. We indicated in the preamble to the proposed rule that, once a State submits a specific methodology in the annual report for estimating the baseline numbers, the State must use the same methodology to provide annual estimates unless it provides a detailed justification for adopting a different methodology. We also noted therein that traditionally, most national estimates of uninsured children have been based on the Bureau of Census March Current Population Survey (CPS). We further noted in the preamble that, as the only data source with the capacity to generate State-by-State estimates of uninsured children, the CPS generally is relied upon by policy makers to provide an overall estimate of insurance status and insurance trends in the nation. We also mentioned other major surveys that provide insight into the number of uninsured Americans.

Comment: One commenter recommended that we require annual reports to contain reasonable utilization measures indicating quality and access to care for children with special needs in addition to the general child population. The commenter believed that the Secretary should conduct a focused study of children with special needs. Another commenter noted that States providing dental benefits should report annually on the assistance provided to recipients in accessing needed services.

Response*:* We are very concerned about services for special needs children, and we agree with the commenters that quality and access are important both with respect to special needs and dental benefits and States are encouraged to address these important areas in their annual reports. However, requiring such reporting would be inconsistent with the flexibility permitted under the statute. At §457.495(b) of this final rule, we require States to provide assurances of appropriate and timely procedures to monitor and treat enrollees with chronic, complex or serious medical conditions, including access to specialists experienced in treating the specific medical condition. We leave it to the States to determine what systems and procedures they will implement to ensure enrollees with such conditions have access to quality care consistent with this standard.

In order for States to create systems which fit their unique programs, the methodology for complying with §457.495 is best left to the State. Reporting on access to dental benefits is subsumed under §457.495(a), which requires States to include in their plans a description for assuring the quality and appropriateness of care provided under the plan including access to covered services listed in §457.402(a). Dental services is one of the optional services States may cover under the definition of child health assistance located at §457.402(a)(16). To the extent that States cover dental services in their SCHIP

plans, they must assure access to those services. Therefore, we have not adopted the commenter's suggestion to add a separate requirement regarding dental services.

Comment: One commenter asserted that HCFA exceeds its authority in the annual report requirements at §457.750(c) that requires States to provide a rationale and description of the methodology used to establish the baseline estimate, if the estimate is based on a source other than the CPS. The commenter contended that the purpose of the annual report is for *States* to assess the operation of their programs. The commenter also argued that HCFA lacked authority to compel States to adopt the CPS standard. The commenter referred to section 2108 of the Act, which provides that the State shall assess its performance and submit that assessment to the Secretary. The commenter noted that providing a rationale for a methodology made States take additional steps that were not prescribed by the statute. In requiring this rationale, the commenter suggested HCFA came perilously close to dictating the CPS standard, which violates the express terms of title XXI and Executive Order 13132, regarding Federalism. The commenter indicated that under Executive Order 13132, HCFA is required to justify the imposition of any national standard and to look for less burdensome alternatives. The commenter expressed the view that the proposed rule improperly shifts the burden of justifying standards used to

evaluate programs from HCFA to the States.

Response: Section 2107(b)(1) of the Act expressly gives the Secretary the authority to require data collection, records maintenance, and reports from the States "at the times and in the standardized format the Secretary may require in order to enable the Secretary to monitor State program administration and to evaluate and compare the effectiveness of State plans." In order to effectively monitor State program effectiveness in reducing the number of uninsured children, the method of detecting the numbers of uninsured in States and the decline or increase in the uninsured must be known and understood in a standardized manner when possible. The statute uses CPS for formula allocating, so it was suggested as the best available source for State uninsurance levels among low-income children. Most States elected to use the CPS in establishing their initial baselines. However, we recognize the shortcomings of CPS for many States and have therefore provided flexibility to use other sources, both initially and prospectively. The requirement that States explain their alternative methodology is necessary and appropriate in order for HCFA to be able to identify and assess the data provided by States. In addition, we have further clarified that if States elect to use a different data source in re-establishing a baseline, the State must also note in the annual report the CPS estimate for that year, both as a means of providing standardized

information across States, using a consistent baseline and to ensure that States are given credit for progress in enrolling children back to the beginning of their programs.

Comment: One commenter requested that HCFA allow States to use biennial State survey figures in assessing changes in uninsurance rather than the annual figures from the CPS. The commenter noted that the CPS data is unreliable for its State and administering an annual survey would be cost-prohibitive for some States.

Response: Section 457.750(c)(1)(ii) provides that a State may base its estimate of the number of uninsured, low-income children from a State-specific survey. Thus, States may use biennial data from State surveys, utilizing statistically relevant adjustments in the off-survey year or by supplementing the biennial data with additional State-specific data from other sources to fulfill the annual reporting requirements of this section. We note that, as stated in the previous response, States will be required to provide a description of the methodology and rationale for using the State-specific survey, in accordance with §457.750(c)(2).

Comment: One commenter urged HCFA to revise the proposed rule to reflect provisions of the Balanced Budget Refinement Act of 1999 (BBRA), which require that the March Supplement of the CPS be expanded to allow State-level estimates of the number of

uninsured children. The commenter believed that using these updated estimates would be preferable to allowing States to establish their own methodologies for estimating the number of uninsured children.

Response: We note that provisions of section 703(b) of BBRA amended Section 2109 of the Act to modify the March Supplement of the CPS to detect real changes in uninsurance rates of children. The BBRA requires future modifications to the Current Population Survey in order to produce statistically reliable annual State-level data on the number of low-income children without health insurance coverage. One modification to the CPS is to include data on children by family income, age, and race, and ethnicity. Adjustments to be made include expanding sampling size used in State sampling units and expanding the number of sampling units in a State. Therefore, with the creation of this requirement, Congress sought to help provide all States with access to more reliable State-level data on the uninsured population through the CPS March Supplement. We have not modified the regulation text to reflect this change, as this data is not expected to be available until October or November 2001. We wanted to leave the regulation text open to future improvements to the CPS or other data sources. Even with the CPS adjustments, there are States that believe they can provide more accurate estimates of the level of uninsured children in their State with methodologies

that use other data sources or sources that supplement the CPS data. We believe it is important to allow States this flexibility in developing the most reliable estimate for their State.

Comment: One commenter supported the required collection of information in the annual report, and recommended we require States to also report on the following information in the annual reports:

-- Progress in addressing the barriers to access experienced by minority children;

-- Grievances, complaints of problems reported relating to enrollment, access, and quality of care as a means of measuring consumer satisfaction, ensuring they are adequate to resolve complaints within a reasonable time frame and that plans use grievance and complaint data to improve quality;

-- Cultural competency measures;

-- Continuity of care between plans, providers, or programs;

-- Special attention to under-served or under-identified populations (for example, homeless children);

-- Systematic integration with schools and other community groups;

-- Whether primary care and pediatric specialty care capacity is adequate for the number of enrollees;

-- Whether plans meet standards for access within reasonable

time frames;

-- Whether care is in accordance with clinical practice guidelines for quality of care; and

-- The proportion of providers who are both Medicaid and separate SCHIP providers among those serving Medicaid and separate SCHIP beneficiaries, and the difference in payment rates to plans or providers in Medicaid and separate SCHIP programs.

-- Estimates of the number of uninsured children under the regular Medicaid income thresholds as well as those under the 200 percent FPL and under the State's SCHIP income threshold;

-- Data on the method of application for Medicaid and SCHIP (mail-in, outstation-site, Internet, etc.) and enrollment procedures for each program;

-- Data on the portion of applicants denied and reason for denial;

-- Number of children disenrolled for any reason, the reason for disenrollment, and the number of children disenrolled for nonpayment of premiums;

-- Number of children continuously enrolled in Medicaid and/or separate SCHIP program for one year or more;

-- Number of children identified by screening as Medicaid eligible and, of those, the number enrolled in Medicaid;

-- Number of former Medicaid recipients enrolled in separate SCHIP;

-- Data on the number of applicants denied eligibility and the reason for the denial, including that they were disqualified due to current insurance coverage as well as the number of children disqualified due to insurance coverage in a past period, where applicable;

-- Number of children who lose coverage at redetermination and the reason for loss of coverage; and

-- Data comparing the proportion of children enrolled and using services by gender, race, ethnicity, and primary language to the proportion of such children in the service area.

Response: As noted earlier, HCFA participated in a workgroup let by the National Academy of State Health Policy to develop a template for States' annual reports that have provided an opportunity for States to report the information required in §457.750 in a standardized way. NASHP released this template to the States and the public in November 2000 for States to use in completing their annual reports for FY 2000. In addition to budget and expenditure data, this will include information from States on their progress in reducing the number of uninsured low-income children, meeting strategic goals and performance measures, the effectiveness of States' policies for preventing substitution of coverage, and identifying successes and barriers in the States' plan design. In addition, the reports provide a forum for evaluating States' progress in addressing specific

issues (such as outreach) and the primary language of SCHIP enrollees. We will work with NASHP to include these elements in a revised version of the annual report framework upon publication of this final rule. States will not be expected to address these new elements until they submit their FY 2001 reports. In addition, because the information can be more appropriately displayed in the annual report than in the quarterly reports, we have added a new §457.750(b)(7) to require States to provide information on primary language of SCHIP enrollees in their annual reports. HCFA will continue to closely review the data collected and reported by the States in their annual reports.

We note that many of these assessment elements were provided by States in their State evaluations. Specifically, as part of the evaluation, States were required, as specified in section 2108(b)(1) of the Act and laid out in the NASHP evaluation framework, to provide information on baseline numbers of uninsured low-income children in the State by income level; levels of previous insurance coverage for applicants and enrollees; and quarterly enrollment statistics including: number of children ever enrolled; new enrollment; number of member months enrolled; average months enrolled; disenrollment including the reasons for disenrollment; unduplicated count of enrollment; and enrollee characteristics, such as income. Many States provided additional information on enrollees' gender, race and

ethnicity in the reports. The annual report template is not as extensive as the evaluation template, but many of the same elements are included. Therefore, States will have the ability to indicate in subsequent annual reports that no update is needed since the evaluations were submitted.

Finally, it should be noted that, as we work toward developing and implementing a national core set of performance measures and goals, we will consider the performance goals suggested by the commenters.

Comment: One commenter noted that the preamble to proposed §457.750(c)(1) was unclear as to whether the program referred to in the phrase "upper eligibility level of the State's program" is Medicaid or SCHIP.

Response: The requirements of subpart G of the regulations regarding strategic planning, reporting, and evaluation apply to separate child health programs and Medicaid expansion programs. Thus, in §457.750(c)(1), we are referring to the upper eligibility level of the State's SCHIP program, which would be the upper eligibility level of either a Medicaid expansion or a separate child health program. If a State operates a combination program, the upper eligibility level would be the highest eligibility level of either the Medicaid expansion or the separate program.

Comment: One commenter recommended that specific measures

be defined either for all SCHIP programs or separately for employer-sponsored insurance model programs based on HEDIS or Healthy People 2000 guidelines, to ensure that all States report similar guidelines and that common agreements could be used across States. Given that some States plan to use an employer-sponsored insurance model for coverage, the commenter suggested that HEDIS measures would seem the most appropriate approach on which to base data collection and reporting systems. For States using an employer-sponsored insurance model, contracts or agreements between the State and carriers would be needed for collection and data provision, this commenter stated. In this commenter's view, States would have to create specific data collection and reporting mechanisms to do this.

Response: The regulations do not require States, including States with premium assistance programs, to collect data on specifically defined measures, except with respect to any core set of performance measures that may be developed by the Secretary at a later date. We encourage States to work with health plans, HCFA, and each other to create standards that meet their mutual needs for data. We particularly encourage States using premium assistance program models for SCHIP to explore effective methods of data collection, but recognize that data collection will present particular challenges to these types of programs because the State may not have direct contractual

relationships with employer group health plans or with health insurance issuers offering group health insurance coverage. States may need to explore alternative methods of data collection for premium assistance programs, such as consumer surveys and polling.

Comment: One commenter expressed concern that the requirement at §457.750(b)(5) stating that the annual report must include an updated budget is unnecessary and duplicative of other ongoing requirements, including the HCFA form 37, "Medicaid Program Budget Report--State Estimate of Quarterly Grant Award."

Response: The requirement for updated budgets in the annual report is necessary for the sound administration of SCHIP. Annual reporting of updated budgeting with three-year projections, including changes in sources of non-Federal funding and details on the planned uses of all funds, is essential to sound financial management of this program. Annual updated reports are also essential to HCFA as it monitors and anticipates the financial needs of States implementing SCHIP programs. Because States have up to three years to spend each annual allotment, a three-year budget is useful to show if States are planning to use their unused allotments in the succeeding two fiscal years or if they anticipate a shortfall in Federal funding. Therefore, we have decided to retain this requirement for a three-year budget in the final regulation. However, we are

no longer requiring a three-year budget with all amendments. Instead, we have limited the requirements at §457.80 to a one-year budget only with amendments that have a significant budgetary impact. A more detailed discussion of this issue can be found in the comments and responses to §457.80.

Comment: One commenter noted that in §457.750(b)(5)of the proposed rule, States are required to include in the annual report an updated budget for the current Federal fiscal year. The commenter states that HCFA did not take into account the State appropriations process and the fiscal year used by the State as opposed to the Federal fiscal year. For example, Illinois has a July-June fiscal year, with the legislature appropriating funds for the final Federal quarter (July-September) in May. Therefore, the commenter noted, the last quarter in the SCHIP annual report will be an estimate. The commenter believed that the regulations regarding the annual report should be revised to permit States to estimate budgets for the final Federal quarter.

Response: We have modified §457.750(b)(5) as proposed. Instead of requiring an annual budget for the current fiscal year, we now require an annual updated budget for a three-year period. We realize that the three-year budgets States are required to submit annually in fulfilling the requirements of §457.750(b)(5) are based on projections and may vary from actual

expenditures for a variety of reasons. However, we believe it is important to have this information to ensure that States have adequately planned for the program and to analyze spending allotments.

7. State evaluations (§457.760)

In proposed §457.760 we set forth the requirement that States submit a comprehensive evaluation by March 31, 2000 that analyzes the progress and effectiveness of the State child health program. In the evaluation, a State must report on the operation of its Medicaid expansion program, separate child health program, or combination program. As specified in section 2108(b)(1)(B) of the Act, the State evaluation must include all of the following:

! An assessment of the effectiveness of the State plan in increasing the number of children with creditable health coverage. In addition, the State must report on progress made in meeting other strategic objectives and performance goals identified by the State plan.

! An assessment of the State's progress in meeting other strategic objectives and performance goals identified by the State plan.

! A description and analysis of the effectiveness of elements of the State plan, including the following elements:

-- The characteristics of the children and families assisted under the State plan, including age of the

children and family income. The State also must report on children's access to, or coverage by, other health insurance prior to the existence of the State program and after eligibility for the State program ends (the child is disenrolled). As an optional strategy, the State also should consider reporting on other relevant characteristics of children and their families such as sex, ethnicity, race, primary language, parental marital status, and family employment status.

-- The quality of health coverage provided under the State process or other process that is used to assure the quality and appropriateness of care.

-- The amount and level of assistance including payment of part or all of any premiums, copayments, or enrollment fees provided by the State.

-- The service area of the State plan (for example, Metropolitan Statistical Area (MSA) or non-MSA).

-- The time limits for coverage of a child under the State plan. As an optional strategy, the State should consider reporting the average length of time children are assisted under the State plan.

-- The extent of substitution of public coverage for private coverage and the State's effectiveness in designing policies that discourage substitution.

-- The State's choice of health benefits coverage, including types of benefits provided and the scope and range of these benefits, and other methods used for providing child health assistance.

-- The sources of non-Federal funding used in the State plan.

! An assessment of the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children.

! A review and assessment of State activities to coordinate the SCHIP plan with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.

! An analysis of changes and trends in the State that affect the provision of accessible, affordable, quality health insurance and health care to children.

! A description of any plans the State has for improving the availability of health insurance and health care for children.

! Recommendations for improving the SCHIP program.

Comment: One commenter indicated that the State evaluation requirements should be less prescriptive and require an analysis of the effectiveness of elements the State may include rather than requiring an analysis of all eight elements listed at

§457.760(c). The commenter asserted that such policy would allow States to identify and address areas relevant to their own State plans. The commenter suggested that we revise this section to provide that "a description and analysis of elements of the State plan ***may*** include:" the elements in paragraph (c) of this section.

Response: States were statutorily required to report on the progress of the elements set forth in §457.760(c) in the State evaluation, due to HCFA on March 31, 2000, and we modeled the proposed regulation text after the statute. Section 2108(b) of the Act specifies the contents of the State evaluation. HCFA therefore does not have discretion to make these requirements optional for States. In addition, because all the States have submitted the required evaluation, we have removed this provision from the final rule. Any request for future evaluations will be based upon the requirements in the statute for evaluations and annual reports on the program.

Comment: We received several comments expressing appreciation that the guidance set forth in the preamble to the proposed rule regarding the evaluation closely followed the evaluation framework developed by NASHP and the State workgroup. However, several commenters asserted that the information provided in State evaluations should not be used to establish model programs and practices. Rather, they noted, States should be given the freedom to design programs that best suit the needs

of their population and circumstances, and information provided in the evaluation should focus on how the States have used the flexibility allowed by the program to create unique and successful plans.

Response: We are using the evaluations to identify model practices. We believe that the identification of model practices should not involve comparing unlike programs or overlooking the unique circumstances of each State. Many States have been eager to learn about other State practices. We envision model practices as a means of sharing information with States and other interested parties on how other States have successfully implemented certain parts of their program. We develop model practices not as a means of judging or evaluating programs, but rather as a means of sharing those practices that have proven successful for one State so that other States may determine the merit of adopting similar practices in their own SCHIP implementation.

Comment: One commenter recommended that we require States to report on the provision of services as well as the participation rates of pediatricians and other child health care providers in the program. Additionally, the commenter recommended that we require States to report the average cost-sharing requirements for families who choose to enroll in SCHIP rather than employer-provided coverage. The commenter believed

that we should also require States to include an evaluation of the impact States' efforts to minimize substitution have had on children with special health care needs and their access to services. The commenter believed that HCFA should also require States to include evaluations of their screen and enroll processes.

Response: We do not agree with the commenter's suggestion. The evaluation template developed by the National Academy for State Health Policy reflects those elements specified in section 2108(b)(1)(B) of the Act. To this extent, it did include assessment questions on the State's cost sharing and its effects on participants as well as questions regarding the State's screen and enroll process and its substitution policies and results of monitoring rates of substitution. We have further included a provision at section 457.353 that specifically requires States to monitor and evaluate the effectiveness of the screening process. The regulatory requirements are consistent with the statute. In some cases, States included additional data or other information such as the data suggested by the commenter, in their SCHIP evaluations as additional measures of their progress toward strategic objectives of that State.

Comment: One commenter supported the proposed categories of evaluation, but requesting that we require more frequent reporting and evaluation.

Response: Section 2108(b) of the Act, as implemented in §457.760, required States to submit evaluations by March 31, 2000. We believe the information States will be providing through the quarterly and annual reports required by §457.740 and §457.750 respectively, will be sufficient to allow ongoing assessments of States' SCHIP programs, making more frequent reporting and formal evaluations unnecessary and overly burdensome on States. The statute did not include a subsequent requirement for an annual evaluation and we have, therefore, removed this provision from the final rule.

Comment: One commenter recommended that HCFA clarify §457.750(c)(1) by replacing the phrase "coverage by other health insurance prior to the State plan" with "coverage by other health insurance prior to coverage under the State plan."

Response: Because we have deleted this provision from the final rule, we have not adopted the commenter's suggestion.

Comment: One commenter recommended that HCFA encourage States to build on existing data collection efforts and systems, including State title V efforts, in developing overall SCHIP evaluation efforts and in collection of data.

Response: We encourage States to build on existing databases and title V efforts, as well as public-private partnerships in order to facilitate the development and implementation of information tracking systems and SCHIP program

evaluation efforts.